The Proposed Federal Management Team Plan of Action

Guam

The Department of Mental Health and Substance Abuse

And

Department of Integrated Services for Individuals with Disabilities

District Court Case CIV 01-00041

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THE PLAN INTRODUCTION

One can theoretically reduce the mandates of the Amended Permanent Injunction (API) into the following format:

- Defendants must ensure that the inpatients at the Adult Inpatient Unit (AIUs) and the residents of the Residential Group Homes (RGHs) all be provided a safe environment. This entails securing the least restrictive facilities that house this fragile population, so that all safety concerns are addressed in a proactive manner.
- Furthermore, the Defendants should be ever vigilant in attending to the health and basic care needs of those entrusted to their care and custody.
- When the Defendants contract with vendors/service providers to care for the target population at RGHs, measures shall be taken to monitor that these entities are similarly compliant.
- Psychiatric care shall be provided to those acutely in need of same (i.e. inpatients at the AIUs), consumers residing in sponsored facilities, and those members of the target population that are awaiting placement (more often than not, these individuals are still cared for by family members).
- Toward that end, Multi-Disciplinary Treatment Teams (MDTTS) shall be formed and evaluations from the various specialties shall determine the individually tailored treatment regimen to be followed.
- Consultations between the sundry disciplines with respect to the type and dosage of a particular medication, as well as the most effective behavior management program to be employed, are expected to occur on an ongoing basis.
- Due diligence shall be exercised to ensure that chemical restraints are utilized sparingly.
- The treatment plans that are generated by the MDTTs should contain detailed goals and objectives for the Plaintiffs and “all those similarly situated,” with attendant incremental time lines for accomplishment of same.
- The psychological and behavioral service adjunct to be provided by the psychologists shall likewise be customized for members of the target population.

- At a minimum, the Defendants shall strive to prevent the self-care skills of those individuals under their care and custody from deteriorating.
- Accordingly, an interdisciplinary approach shall be implemented to determine those specific areas in which each of the aforementioned needs training.
- These coveted interventions shall include occupational, physical and speech therapy, where indicated.
- In short, Multi-Disciplinary Master Treatment Plans shall detail the respective medical, behavioral, habilitation and treatment needs of each member of the target population.
- Finally, the Defendants shall develop a wait list and grievance process, as well as a comprehensive plan to provide needed residential facilities, along with community services/supports.

The underpinnings for the Judgment that was entered, as well as the concomitant API in the subject case, can be found in the Findings of Fact and Conclusions of Law ((Doc. No. 276). In rendering the Decision, this Honorable Court evaluated whether the Plaintiffs, while ensconced within the AIU, had been receiving care and treatment in accordance with their Constitutional and Federal statutory rights. Following the lead of Olmstead v. Zimring, 527 U.S. 581 (1999), Judge Marshall found that the Defendants were obligated to provide services to the Plaintiffs in the most integrated community setting appropriate to their respective individual needs. The Court further relied upon Youngberg v. Romeo, 457 U.S. 307 (1982), for the proposition that "individuals similarly situated in Defendants' facilities" have a right to reasonable safety and adequate health care, as well as "habilitation" in order to prevent regression. With this backdrop in mind, the following plan is designed to shore up the Defendants' long-standing deficiencies, in terms of complying with what was called for in the API, while simultaneously implementing measures commensurate with both the Olmstead and Youngberg holdings.

In sum, the Plan that follows will endeavor to overcome the current challenges which effectively deprive those within the "target population" of their right to live outside an institution, as a member of the community. At present, there exist a significant number of individuals that are

institutionalized or at risk of institutionalization, which is directly attributable to a lack of community based services. True community integration, to which the subject Plan aspires, reflects the capacity of the Department to support and sustain a consumer physically, socially and psychologically. Toward that end, the FMT will orchestrate the provision of court-mandated services to members of the target population in the most integrated community based setting appropriate to their respective needs.

Section 2: The Center

Challenge/Issue:

Staff at the Residential Group Homes (RGHs) are currently providing training to members of the target population, as well as conducting skill building exercises (i.e. activities of daily living). This is consistent with the residents' right to habilitation, which endeavors to prevent an individual's pre-existing self-care skills from deteriorating. Although the professional staff have conducted assessments, as well as formulated written treatment plans (delineating goals and objectives for residents), the actual delivery of such services are dependent on the group home staff. Notwithstanding the fact that several steps have been undertaken to improve the competency level of the staff such as modeling, classroom instruction and over the shoulder training, the residents' response to training has been poor.

The professionals that travel to the group homes to render the subject services (i.e. counseling, occupational therapy, behavior management, etc.) have encountered crowded conditions, frequent interruptions and a lack of privacy, which invariably decreases the effectiveness of said service array. Furthermore, the DMH main facility lacks adequate space to provide the services and there is a continual need for the utilization of extra staff, in order to escort the consumers.

THE CENTER

At the heart of the system of care is one large, 39,000 square foot, multipurpose day center for treatment, services, programs, training and evaluation. The Center was designed for this purpose and architectural drawings completed in November 2009 have been purchased (See Exhibit 1 [Rendering], Exhibit 2 [First Floor] and Exhibit 3 [Second Floor]). The approximately three acre parcel of land is centrally located and currently sitting idle, waiting for the construction process to begin (funding, RFP, contractor selection, etc). Unfortunately, no funding for the project has been identified.

The Center will be the focal point of delivery of the services and programs envisioned in the API. Psychiatrists will see clients in The Center to monitor the medications and have

immediate contact with other professionals to assess medications' therapeutic effects, as well as detect adverse side effects. Psychologists will conduct evaluations, monitor treatment programs, gather behavioral data and immediately adjust individual behavioral programs, where indicated. Social workers will evaluate ongoing needs, engage the consumers in social skill building activities and orchestrate what is needed for any transition, in terms of level of care. Occupational therapists (0T) will oversee and conduct skill building in Activities of Daily Living (ADL), along with Instrumental (i.e. advanced) Activities of Daily Living (IADL) and programming. Speech therapists (ST), as well as physical therapists (PT) will conduct evaluations and therapy. An internal medicine and/or family practice medical doctor will be available part-time to monitor the primary physical health needs and to make referrals to specialty clinics as needed. Employment services, both job training and placement, will be provided by The Department of Labor and the Division of Vocational Rehabilitation (DVR), utilizing continued federal funding. Services for both the vision and hearing impaired will be available.

Multidisciplinary Treatment Teams (MDTT) will meet in The Center to provide initial and annual evaluations. Core professionals comprising the teams will be readily available to attend the meetings, to map out future treatment needs and develop transition plans. Psycho-educational classes will be conducted for the consumers and their respective families.

Where appropriate, the consumers living in the sponsored facilities will be transported to The Center each week-day to attend individual programming and skill training. The Center will also engage outpatients, who currently reside with family members (eg. on the planning wait list, thus within the target population), by encouraging these consumers to access services and programs, which should theoretically extend the length of time the families will be able to provide home care and thereby reduce the burden on the system of care, in terms of residential placement.

Should a client feel ill, a medical doctor will be available to examine and treat the consumers' medical maladies. By improving access to medical services, diseases and high risk conditions will be discovered early, treatments less intrusive and more effective, thereby

reducing the alarming death rate of those in the target population. Partnering with the Department of Public Health and Social Services will lead to each client having a primary care physician. Because of the extensive equipment requirements, which are inextricably related to the provision of dental services, the Department has contracted with two (2) local clinics, as opposed to providing such care at The Center. Nonetheless, appointments and transportation will be coordinated through The Center.

The Center also provides a rich opportunity for students to engage in practicum and internships from the University's counseling program, social work master's degree program, master's degree in clinical psychology and nursing program.

Most offices for the professionals (psychiatrists, psychologists, social workers and counselors) will remain at the current DMHSA building (The Center is located about a mile's distance from DMHSA) to service the two (2) adult inpatient units and be available for the outpatient clientele. This arrangement provides for better utilization of office space and obviates the need to provide same in The Center. Notwithstanding, some professionals will maintain offices in The Center (i.e. OT, PT, ST).

The Personal Care Attendant (PCA) program (see Section 3: Personal Care Attendants) will operate out of The Center. Consumers can be assessed more thoroughly at The Center to determine their PCA needs. The members of the target population will be introduced to their individual PCA and train with the assigned PCA. In doing so, the needs of a particular individual can be identified and conversely, the prospective clients will learn the role of the PCA in support of an integrated community living program.

The Center is an ideal location for the Peer Support Program. Peer support consists of non-professionalized assistance from people who share similar life experiences, have endured many of the obstacles facing the consumers and yet ultimately prevailed. Mental Health Peer Support Navigators share their travails, in terms of having to cope with a mental illness; personal reactions to traditional services; describe what a power-shared relationship can resemble; explain the need for mutual responsibility; convey the need to work with conflict; make anecdotal

references to proactive crisis planning and essentially portray what is possible. The consumers volunteering for this alternative program will be trained in accordance with Peer Support procedures and begin working under staff supervision before engaging in the full Peer Support activities.

Self-Directed Care: Client-driven needs, desires, services and programs must be an integral part of the overall service scheme, where consumers can select from a menu of programs and services. Programs not available, but needed, can be researched and developed at The Center to provide true self-directed care. The Center will provide a logical gathering place to conduct frequent community meetings where clients can articulate concerns and simultaneously identify their aspirations. The ideas expressed will be discussed and incorporated into the array of services/programs offered.

Recreation and exercise activities will be built into the system of care at The Center. A skilled recreation therapist will have the facilities, equipment, and resources to plan a full complement of therapeutic activities both within and outside The Center. This venue will be the central gathering place and as such, the lynchpin, from which out-reach activities will emanate. Vehicles will be assigned to provide transportation to outside activities, as determined by the recreation therapist.

Case Management is a key component linking the most appropriate community based services with the client. The Center provides a facility where true intensive case management can flourish due to frequent direct observation and assessment of the client, as well as provide collaboration. The full menu of programs and services will be available to the case manager, which will not only link consumers to services promptly, but allow staff to monitor the respective consumer's progress. Those members of the target population requiring intensive case management will be identified and assigned to social workers designated for this program. Intensive case management may be needed for clients who have multiple admissions to the inpatient units and require additional services to stave off recidivism.

The Center concept may be unique to Guam, due to its small footprint. In other words,

this centrally located facility is no more than 30 minutes from any point on the Island. Consumers will generally be able to access public transportation, however alternative arrangements can be made.

TIMELINE:

Hire a Project Manager for the construction – 6 weeks from POA approval

Construction to occupancy – 24 months from POA approval

COST:

Current construction estimates obtained from architects is $190/sq foot plus 10 percent - $8,360,000

Increased staff and operational costs are detailed in Exhibit 4, overall cost spreadsheet.

Section 3: Personal Care Attendants

Challenge/Issue:

A Personal Care Attendant Program (PCA) is nonexistent within the present system of care. This critically needed PCA program will support a host of other community service programs, including *inter alia*, placement of consumers into semi-independent living situations, as well as preserving current arrangements where members of the target population are residing with their families, thereby decreasing the reliance on and encumbrance of government funded programs and services.

CULTIVATE A CORPS OF PERSONAL CARE ATTENDANTS

The U.S. Department of Housing and Urban Development (HUD) administers federal aid to the island through the Guam Housing and Renewal Authority (GHURA). This local Agency currently has seven hundred and fifty-one (751) public housing units located throughout Guam. Section 8, Mainstream and Shelter Plus Care constitute programs that provide vouchers to very low-income families, the elderly and persons with disabilities. It is noteworthy that Shelter Plus Care rental assistance is available for homeless individuals with chronic mental illness or other disabilities, in connection with services from outside the program.

In order to maximize the utility of the Shelter Plus Care Program, as well as Mainstream HUD funds and thereby promote community integration for those eligible members of the target population, for whom independent or semi-independent living constitutes a viable option, a cadre of personal care attendants (PCA) must be created. Personal care services are those related to a recipient's physical requirements. A litany of such services should include assistance with eating, bathing, dressing, personal hygiene, activities of daily living, bladder/ bowel requirements and taking medications. Provision of this service array enables an individual to remain in his or her home/community, maintain their current health status and prevent, delay or minimize deterioration of an existing condition. As noted earlier, the utilization of personal care attendants could also be utilized to supplement care provided by an individual's family or primary care giver. In certain cases, where appropriate, family members could be hired as PCAs to care for an individual within the family. The peer support program will dovetail with the PCA program whenever possible.

The FMT would be responsible for, not only securing qualified personnel for the PCA positions, but also arranging a training program for same. The Department however, would assume responsibility for determining the amount and duration of the services to be provided by the PCA (which in all likelihood would be contingent upon the severity of an individual's condition). In terms of organizational structure, the PCA program would fall within the province of the Psychology Division.

In sum, by cultivating a PCA program and promoting true communal integration, the mandate set forth in the Olmstead decision can be realized.

TIMELINE

1. Hire a professional master's degree level psychologist to develop and implement the PCA program – Estimated Date of Completion (EDC) – August 2010
2. Contract with Direct Care Support Educational Programs, an on-line service, to provide the curriculum and demonstrate the requisite skill set for the soon to be indoctrinated and psychiatric technicians alike. – September 2010.
3. Hire PCAs, the initial contingent is to be amassed by securing approximately 2 per month, until an estimated 31 are available – October 2010 to February 2012.

COST

1. Psychologist to implement the PCA program: $68,750 (salary $55,000 plus benefits)
2. Contract with College of Direct Support, annual cost: $29,000 (3 year $87,000)
3. 31 PCAs at $25,000 each: (salary $19,000 plus benefits and incentives as PCAs complete the course work) Total $775,000 over FY 2011 to 2012.

Section 4: Community-Based Living

Challenge/Issue:

Prior to the appointment of the FMT, the Department was not utilizing existing vouchers for the Shelter Plus Care (S+C), a HUD sponsored program. Two reasons were proffered: 1) use of the vouchers was not a priority within DMHSA for either moving individuals from the wait list or out of group home placements and 2) the system in place for tracking the efficacy of services rendered, along with the concomitant reporting requirements of GHURA, were perceived by the Department as particularly arduous, given the lack of an electronic means of collecting data and/or billing system in place. As a result, placement into residential group homes was the sole option for members of the target population, if the families were unwilling or unable to provide care and supervision.

SHELTER PLUS CARE PROGRAM

True communal integration can be realized by utilizing the S+C vouchers which are readily available from GHURA (the local branch of HUD) to underwrite the cost of a consumer's rent and utilities. The FMT will ensure that DMHSA is taking full advantage of this program and monitor whether the weekly reports for each placed consumer (a requirement set forth by GHURA) are being generated in a timely manner.

When the FMT was appointed on March 2, 2010, a lone individual was taking advantage of the Shelter Plus Care system, however as of July 1, 2010, 25 members of the target population are now enrolled in the program.

In addition to the use of the S+C and Mainstream programs available via HUD, the FMT plans to establish a series of supervised, partially supervised or unsupervised home and apartment living settings. Placements in these settings will be determined by the professional staff, in tandem with the consumers' desire. A series of settings will be posited, each less restrictive, but supported by community-based services (i.e. those services deemed necessary to assist members of the target population in moving toward independent living). (See Section 8: Residential System).

TIMELINE

1. Use of Shelter Plus Care vouchers has progressed at an remarkable rate to the point where additional vouchers are being required by GHURA from HUD. All 25 vouchers available have been utilized as of July 1, 2010.

2. The development of the overall housing schema timeline is listed in the Residential System, Section 8.

3. The development of an electronic data base system for clinical notes and billing of services is listed in Management Information System, Section 17.

COST

The utilization of the S+C vouchers saves money by moving or keeping individuals out of the Departments' Residential Group Homes. Group home placement costs vary, but average $85,000 annually, per individual. Service costs remain relatively constant whether an individual is in a group home or in the S+C program, however when a consumer is utilizing the S+C program, the cost of services provided by the Department is used as matching funds for the S+C rent and utilities paid by HUD. As a result, net savings generally realized are about $60,000 for each individual placed.

Costs associated with the Data System and Residential System are listed elsewhere in the POA. (See Sections 17 and 8 respectively)

Section 5: Mobil Community Treatment Outreach Teams

Challenge/Issue:

All psychiatric services are rendered at either the medication client or within the Adult Inpatient Units at DMHSA. The Department utilizes a Community Outreach Team (similar to an Assertive Community Team, sans psychiatric services) on a limited basis. This hybrid version is employed, since only certain individuals and organizations (i.e. Skilled Nursing Unit and Guam's lone nursing home: St Dominic) are on the receiving end of, what can safely be classified as a less than exhaustive, service adjunct. As a result, a myriad of psychiatric needs in the community go undetected and needless to say, the treatment regimen for same is wanting.

To provide genuine community based services, which are individually tailored, a full Assertive Community Treatment team model will be adopted with one Assertive Community Team.

ASSERTIVE COMMUNITY TREATMENT OUTREACH TEAMS (ACT)

The FMT will encourage the utilization of mobile community outreach teams, but will ensure that it is tailored to the individual consumer's needs. Notwithstanding, a full complement of mental health professionals (Assertive Community Team (ACT): psychiatrist, psychologist, social worker, nurse, and/or counselor), will additionally be deployed to render community-based treatment to members of the target population who are currently cared for by family members (i.e. consumers on the wait list). At other times, when a full team is not considered necessary, the community outreach team (COT) will be appropriately constituted. The end result will be a flexible approach to community outreach, dependent on the needs of the client being served. The members of these teams can be expected to coordinate case management, provide psychiatric, as well as psychological services and conduct initial, along with ongoing, assessments. The ACT will be dispatched to the Department of Corrections, the Skilled Nursing Unit, along with St. Dominic and attend to the needs of the individuals in these facilities. See http://www.actassociation.org/actModel/ for detailed responsibility, principles and services the ACT will bring to the system of care.

The use of this flexible approach is considered to better serve the needs of the consumers (i.e. client driven and will preserve resources).

TIMELINE

1. The FMT will need to develop policies and procedures governing the utilization of the mobile community outreach teams. EDC – December 2010.
2. Additional professionals will be hired to support the community outreach teams however none are being hired to specifically constitute the team. EDC – Jan 2011

COSTS

Since professional will be assigned other duties (i.e. extraneous to the ACT or COT), their respective salaries are estimated as a percentage of FTE costs.

Psychiatrist - .25 FTE -	(240k*.25)= $60,000 in FY 2011
Psychologist - .25 FTE	(140k*.25)= $35,000 in FY 2011
Social Worker - .40 FTE	(40k*.4)= $16,000 in FY 2011
Nurse - .5 FTE	(55k*.5)= $27,500 in FY 2011
Counselor - .4 FTE	(40k*.4)= $16,000 in FY 2011

Section 6: Integrated Community Living

Challenge/Issue:

Individuals remain in Residential Group Homes (RGHs) due to a lack of community-based services, including *inter alia,* an appropriate level of training, PCA support programs or the use of Federal housing assistance programs.

INTEGRATED COMMUNITY LIVING

To comply with the integration mandate espoused by Olmstead, community-based, local and Federal programs will be accessed, in order to provide clients housing, with appropriate supports and services to sustain such a communal living arrangement.

The Personal Care Attendant (PCA) program will be implemented as previously described in both Sections 3 and 4 herein. PCAs will be used extensively to support families and enable them to extend the time they are able to provide care for loved ones within their respective homes, as well as provide the needed assistance to clients living in independent/semi-independent, integrated community placements. Federally funded programs through HUD, administered by GHURA locally, such as the Shelter Plus Care Program will be utilized to the fullest extent, in order to move clients out of RGHs and into the community.

The Mainstream, Shelter Plus Care, Veterans Assistance Shelter Housing (VASH), and Family Unification Program (FUP) programs will be used extensively to shift the financial burden from the local government to the Federal government. In some cases, dollar for dollar matching of community based services is required, which might conceivably include transition plans that will create links to supportive services such as attendant care, vocational rehabilitation services, substance abuse treatment, mental health services and assistance with meals.

Personnel needed for community-based services in support of full community integration and intensive case management are as follows:

PCAs
Occupational Therapists
Behavioral Therapists
Counselors

Social Workers

Program Coordinators

TIMELINE

These will be an initial hiring of the above listed personnel at Plan approval plus 6 months followed by a second round of hiring two months prior to The Center occupancy and commencement of operations.

COST

PCAs (as outlined in the PCA chapter, Section 3)xxxx

Occupational Therapists I – 3 FTE - salary $40,000 FY 2011 - $120,000

Occupational Therapist II – 2 FTE – salary $50,000 – FY 2011 - $120,000

Behavioral Therapists I – 5 FTE – salary $40,000 – FY 2011 - $150,000

Behavior Therapist II – 1 FTE – salary $45,000 – FY 2011 - $33,750

Counselors – 5 FTE – salary $40,000 – FY 2011 - $150,000

Social Worker Administrator – 1 FTE – salary $55,000 – FY 2011 $55,000

Social Worker I – 3 FTE – salary $30,000 - FY 2011 $60,000
FY 2013 $30,000

Social Worker II – 3 FTE – salary $35,000 – FY 2011 $70,000
FY 2013 $35,000

Social Worker III – 2 FTE – salary $40,000 – FY 2011 $40,000
FY 2013 $40,000

Social Worker Supervisor – 1 FTE – salary $50,000 – FY 2011 $50,000

Program Coordinator – 3 FTE – FY 2013

Administrative Support – 4 FTE – salary $25,000 - FY 2011 $25,000 (for SW)
FY 2013 $75,000 (The Center)

Section 7: Consultants' Assistance with Clinical Issues, Training, Policies and Procedures, Vocational Rehabilitation, and Construction

Challenge/Issue:

The technical assistance on overall management and clinical issues provided by SAMHSA and others over the past several months have exhausted the respective funds which had been set aside for Guam's assistance. The professionals contracted by SAMHSA expressed a willingness to consider biding on a consulting contract via RFP.

The Department lacks a Training Division, individuals to conduct said training, data to track completion of a specific training curriculum, any protocol to denote the need for required recertification or a systematic approach to secure such training.

The Department has been unable to update their policies and procedures (P&Ps), notwithstanding the existence of a Court Order which highlighted this critical area, along with a completely referenced library of JCAHO-ready P&P templates from a commercial company (MCN), which has been at its disposal for the past 2 and a half years. There have been false starts and a sporadic flurry of activity as Status Hearings approach, only to dissipate when other priorities garner attention. Bottom line: very few P&Ps have successfully navigated the process, which entails development, implementation and training on same. As a result, the DMHSA is currently operating with an antiquated set of P&Ps that was created over 15 years ago (some over 20 years ago), with very few having been either updated or revised.

The Division of Vocational Rehabilitation has not been successful in finding employment opportunities for members of the target population and failed to submit the required data to their Federal grantors placing the overall program in jeopardy. In fact, the Rehabilitation Services Administration (RSA), under the Federal Department of Education, suggested a consultant was needed to turn this Division around.

The construction of large projects on Guam is fraught with pitfalls, cost overruns and delays necessitating a construction project manager to navigate this complex area.

ENLISTING THE SERVICES OF CONSULTANTS

The FMT would be responsible for both hiring and deploying a sufficient number of qualified professionals (i.e. behavioral psychologists), along with the required allied health professionals (i.e. occupational, physical and speech therapists), necessary to provide the target population with adequate supervision, medical and mental health treatment. In addition, expert consultation from The Substance Abuse and Mental Health Services Administration (SAMHSA), The American Psychological Association (APA) and The National Association of State Mental Health Program Directors (NASMHPD) have been enlisted at no cost to date, however as indicated above, funds for such technical assistance will soon be exhausted.

The FMT is in a position of "going it alone," with regard to clinical management or securing the services of a consulting team similar to the technical assistance offered to date by SAMHSA and NASMHPD. Having fastidiously pored over the reports generated by expert consultants previously retained by the Department (i.e. Chad Morris and Steve Hamowicz, along with Silverlake Behavioral Associates), the FMT intends to use outside experts that are familiar with mental health system transformations and Guam's unique challenges.

A viable effective training program is needed by the Department, yet none exists, upon which to build. A consultant is needed to establish a vibrant, enthusiastic, ongoing program within the Department to support the myriad activities foreseen in this plan.

Separate and apart from this training adjunct, an entire compendium of equally crucial policies and procedures would be selected and working drafts prepared by the FMT, at which time, the Divisions of DMHSA would provide input, with an eye toward finalizing them. The importance of training and development, along with implementation of governing P&Ps (all of which can be expected to be overseen by the FMT, working in concert with the consultants assisting with clinical management) cannot be overemphasized.

Utilization of a construction project manager is necessary to have structures built on time without errors and cost overruns. Such a person or firm will be contracted via the RFP process

for professional services.

TIMELINE

Clinical Management consultant – 2 months after plan approval

Training program consultant – 4 months after plan approval

Vocational Rehabilitation consultant – 2 months after plan approval

Construction project manager – 2 months after plan approval

COSTS

Clinical management consultant – FY 2011 - $500,000

Training program consultant – FY 2011 - $200,000

Vocational Rehabilitation consultant – FY 2011 - $300,000

Construction project manager – FY 2011 - $800,000 (estimate 5 %of construction value)

Section 8: Residential Settings: Group Homes to Department Funded Apartments

Challenge/Issue:

DMHSA possesses, but two environments for members of the target population: residential group homes and the adult inpatient units. In fairness, as mentioned earlier, great strides have been, as of late, to utilize HUD funded vouchers in order to secure independent apartment living situations.

Notwithstanding the goal of SAMHSA, *to wit:* full supportive, integrated community placements, residential group homes (RGH) will remain as part of the landscape in the full system of care continuum on Guam. Since a RGH constitutes the most practical and effective setting, it will, in all likelihood, be the life-long domicile for a class of individuals requiring a high level of care due to severe/profound cognitive deficits or mental illnesses. Nevertheless, the majority of clients, with appropriate individualized services and the accompaniment of support, training and treatment, can be expected to progress to successful placement within a community setting.

RGHs will also be needed, albeit not for all members of the target population, in order to house clients as they transition through the level of care system being developed. These will be temporary placements, utilized while training and skill building is taking place. In order to overcome any reasonable facsimile of institutionalization, movement of these residents will invariably be based upon a level of care continuum with the avowed goal of full integrated, community placement.

At present, the Department owns one (1) residence, a six bedroom facility of about 5000 square feet in the village of Asan. Other homes are owned (or leased) and operated by for profit (1) and nonprofit (2) service providers/vendors that render a partial array of services. To date, the primary problem has been the lack of movement even with the transitional homes and although consumers appear ready to progress, no movement out of the homes into a less restrictive, community setting has occurred. Another glaring deficiency is that Guam has no effective licensing statute governing group homes (licenses are only issued under children's day care and foster home facilities). This inertia, in terms of moving residents into a community setting, contradicts SAMHSA's goal to eliminate or move away from the group home concept of

providing care to this population.

RESIDENTIAL GROUP HOMES

A significant component of the psychosocial rehabilitation process is instilling a sense of self worth and hope in individuals. Pleasant, relaxed, quiet living quarters are pivotal in the development of self esteem and reflect a show of respect for the consumers. Conversely, cramped and depressing living situations complicate the training/rehabilitation process, effectively reducing, if not nullifying, any hope for progression.

The FMT is fully cognizant that the use of group homes to house the target population permanently is simply another form of institutionalization. Furthermore, the use of group homes does not meet the standard of "community integration" or "supportive community living," as envisioned by SAMHSA and the Bazelon Center. In fact, the trend nation-wide, to which Guam should aspire (in order to realize true integration, in terms of a communal setting, as per Olmstead), is to move away from utilizing RGHs and in its stead, promote independent or semi-independent living arrangements for eligible consumers. Notwithstanding, both SAMHSA and Bazelon realize the use of group homes is necessary (where appropriate, based on an individual's needs) as a temporary measure, as clients receive the training required to progress to a fully integrated community setting. Both SAMHSA and Bazelon also acknowledge the living setting must be "consistent with individual needs." For instance, a subset of the target population that are severely or profoundly retarded and either permanently nonambulatory or extremely debilitated, obviously require more intensive care and therefore may not be capable of taking advantage of the aforementioned living arrangements. Accordingly, a finite number of group homes will need to be a staple of Guam's system of care, but used appropriately in a level of care strategy.

The present system consists of 8 residential group homes that accommodate 61 consumers. The waitlist numbers fluctuate, but has hovered between 50 and 80. It is noteworthy however that 84 developmentally disabled consumers, overseen by DISID, are currently in family placements but the families are seeking residential care in the future when the family anticipates they are no longer able to provide care. Needless to say, with the imminent

absorption of DISID into DMHSA, these individuals will become the responsibility of the Department. These numbers do not include the 5 clients currently off island receiving treatment or the individuals aging out of the juvenile facility, that are expected to transition to adult facilities.

The proposed system of residential care will be an amalgam of residential group homes, along with a contingent of apartments rented by the Department. Two of the 8 residential group homes presently on the grid will remain in the inventory. Karidat Mangilao A, which is a 9 bedroom facility, that opened in 2007 and houses the highest level of care clients in the system (generally individuals with co-occurring disorders of mental illness (MI) and developmental disabilities (DD). Also to be retained is the Guma Ifil Uno, a 6 bedroom transition home owned by DMHSA, a six bedroom facility, which opened in 2004 and is the domicile for chromic MI clients who need intensive case management to avoid recidivism (i.e. return admissions to the AIU). As an aside, the Guma Ifil Uno facility might be redesignated, in terms of the level of care, as the system matures.

Two other smaller homes, specifically designed as communal living facilities in 2002, each with 5 bedrooms, Independent Group Home and Mary Clair, will continue to be operated under contract with the non-profit Guma Mami Corporation, although their primary function will depend on the needs of the system.

Construction of four (4), 4 bedroom homes will be initiated in villages on Government land. The homes will closely resemble average Guam homes, one story, 2 or 3 bath, estimated to be 2500 square feet. These homes will house up to four clients each and have different levels of supervision from 24/7 supervision to no on-premises supervision, depending on the needs of the residents.

Construction of two (2) cluster studio apartment complexes, each with 6 studio apartments. Each one bedroom apartment will house a single client and supervision will be on premises in one of the six, yielding a total of 10 units available for clients. Each unit will be small (i.e. less than 700 square feet, but self contained.

Rental of 8 to 12 one or two bedroom apartments, each scattered throughout the island in existing commercial complexes. It is envisioned these apartments will be used to house individuals who are waiting on GHURA housing in the Section 8 program, government housing or Shelter Plus Care program.

The total number of beds in this array of facilities is estimated to be 63 with another 50 in GHURA sponsored housing or 113 members of the target population.

The homes will not need a staff proficient in implementation of complicated skill develop programs and in fact, will only have to be staffed when the clients are present (see The Center, Section 2). Staff ratios can remain low, but invariably depend on the level of care need. Contracts with current vendors are envisioned to staff the homes. However, the new clusters of studio apartments, homes and apartments will be operated by DMHSA, with standardized policies and procedures, as well as similar operating instructions, both provided by the Department. The homes can also be expected to be maintained with routine cleaning, maintenance and safety inspection schedules by the Department.

Bottom line: the FMT will assume responsibility for orchestrating the training needed by the staff at the RGHs, since mere placement of a consumer by the Defendants into one of these facilities, without a well communicated treatment plan, hardly comports with the continuity of care requirement envisioned by the API. In addition, a notice to cure will be dispatched to any and all vendors/service providers that do not adhere to the terms and conditions set forth in their respective contracts.

Finally, the FMT will take it upon themselves to impress upon the Legislature the need for a licensing statute to govern the residential group homes on island (which incidentally, was drafted by the Court Monitors in November of 2008) .

TIMELINE:

Begin design to construct of 4 – 4 bedroom homes in villages December 2010, duration 14 months

Begin design to construct of the 2 cluster complexes – February 2011, duration 18 months

Rental of 8 apartments by the Department – January 2011 with additional units rented as needed.

COST:

Design and construct 4 housing units of 4 bedrooms each, about 2500 square feet, estimated at $150 per square foot, on government land - $1,500,000.

Design, build, furnish two - 6 studio apartment cluster apartments, each studio 700 square feet (4200 square feet) in two locations – estimate $175 per square foot, $1,470,000.

Rental of 8 to 12 two bedroom apartments in commercial complexes on in various villages, estimate rent and utilities ($1500 each) - $144,000 to $216,000 annually.

Section 9: Level of Care

Challenge/Issue:

At present, several level of care schemata are being used by the Department and service providers/vendors. The situation has evolved as a result of confusion, coupled with limitations regarding the funding sources of contracts, inconsistent leadership over the years, along with the two departments (DMHSA and DISID) pulling in different directions. The Level of Care (contracts) and Residential Treatment Fund (RTF) contracts utilize different funding streams that are administered by different departments. LOC by DMHSA (although previously by DISID) and the RTF by Department of Administration. Service providers/vendors have come to the realization that the RTF can also tap into the Government of Guam's General Fund by law, thus payment is more prompt and less constrained by set budgets. Accordingly, the RTF has become the preferred funding source and service providers/vendors have sought, via local court order, to have invoices paid from this account.

As a result, level of care has taken a back seat to the coveted funding source available through the RTF. The end result is a fragmented level of care system associated with the RGHs that is compounded by amorphous distinctions (in terms of the different levels of care), rendering placements less effective.

SERVICE PACKAGES

The overarching goal is to provide full community integration in supportive living settings (independent and semi-independent housing) for the greatest number of consumers possible and ensure that an array of community-based services is available to families caring for their respective loved ones. Whereas the previous focus was on a distinct level of care concept, a strategic shift in providing services will be on the stated desires and current behaviors or needs, with the coveted goal, stated quite simply: recovery for each person. In fact, success has been found in other communities, when divergent level of care populations were comingled. In other words, higher functioning clients began to assist in the recovery process of others. The shift will view services, not in terms of where individuals are placed, but in the intensity and nature of the services needed. Introduction of the term Service Pack will emphasize the shift or change

from level of care placement to the client's need for intensive services, in an effort to promote recovery.

Clients had been previously placed in accordance with the professional's determination of a needed level of care. The Service Pack concept is based on observing a client's behavior and determining the intensity of services needed based on particular skill sets demonstrated and equally, if not more importantly, on the desires of the client. Generally clients have preferences and can determine their needs, along with the attendant increments in services necessary for recovery. Intensity is defined both by type of service and frequency. For example, Intensive Case Management may be daily contact, a session with their social worker or weekly/ biweekly group therapy sessions all targeting recovery. All services available: behavior, occupational, speech, physical, counseling, skill training, vocational services, psychoeducational, etc. will be factored into service packs.

A part of the system of care is a logical series of settings based on the intensity of service available in each setting outside of the acute inpatient units. A system will be implemented which will include a determination of need through the MDTT process, wait lists for placements and services based on acuity (plus other factors), as well as a procedure for the client or guardian to challenge the determination and placement.

Services available in The Center will be graduated based on intensity but will be applied in a highly individualized fashion according to each client's treatment plan. As consumers progress in their treatment plans, changes will be made in Service Packs and placements. An expanded arrangement of placements will be available (see Section 8: Residential Placements) and unique situations can be accommodated.

A unified funding source for residential placements will be sought via a change in Guam statute. The Service Pack system will be organized, by virtue of a uniform set of policies and procedures, which shall be utilized when conducting assessment and treatment planning.

TIMELINE:

Develop the Service Package concept with consultants and Department's professionals with initial product in April 2011.

COST:

None

Section 10: Medical Services

Challenge/Issue:

The clients are not receiving consistent medical care through a primary care system or assigned physician. As a result, medical conditions may be going undiagnosed and treatment is wanting until symptoms manifest.

UTILIZING THE MEDICAL SERVICES OF A SISTER AGENCY

Physicians specializing in Internal Medicine from the Department of Health and Social Services (DPHSS) will be enlisted to supplement the medical care requirement of the API. Counsel for both parties will be approached with respect to this idea, to ensure such a notion is fully supported. It is envisioned that the DPHSS internists could attend to the residents at the RGHs who currently receive, at best, a modicum of care for their co-occurring medical maladies. The FMT could be expected to coordinate this collaborative effort and draft a memorandum of agreement/understanding, to assure a primary care system is developed and implemented for members of the target population.

The FMT is open to suggestions, as to the most efficient method to provide said care. The DPHSS may opt to assign an internist/family practitioner to attend to members of the target population within the RGHs, although a treatment room will ultimately be available at The Center, as indicated within Section 2. If necessary, DMHSA will budget for a portion of the physician's salary to assist the DPHSS in rendering the service.

Full medical records will be available to coordinate care through the e-health records system (see Section 17).

TIMELINE:

Coordinate with DPHSS on an efficacious method to provide medical services to the target population and establish a Memorandum of Agreement/Understanding – January 2011.

COST:

Medical Doctor - .3 FTE - salary $200,000 – in FY 2011 - 45,000

Section 11: Treatment Process

Challenge/Issue:

Several problems contribute to a rather disjointed treatment process, although improvement has been detected within the past 60 days. The MDTT process has been hampered by the paucity of clinical psychologists, along with the absence of policies and procedures to provide consistent, documented procedures. The lack of direct care service professionals attending to the needs of consumers in the RGHs can also be attributable, in part, to a poor organizational structure at the Department.

TRANSFORMATION OF THE TREATMENT PROCESS

The FMT can be expected to transform the arguably dysfunctional treatment process that is currently in place. The rift between the two disciplines (i.e. psychiatry and psychology) has been resolved with open, frank communication. Clinical staff meetings are conducted two to three times a week, to not only resolve specific client issues, but address systemic problems.

The FMT will be responsible for ensuring the target population's treatment is appropriate, individualized, coordinated and properly managed. In the long term The Center will provide an outstanding venue for full service treatment in occupational therapy, speech therapy, physical therapy, social skills training, behavior management of problem behaviors, PCA training and coordination and vocational skills training. Furthermore, it will be a training center for university students to conduct supervised practicum placements and internships. Quality Assurance will be in place, as well as a quality improvement program. Assessment and coordination of services will be greatly facilitated, with the implementation of required electronic documentation; tracking progress on a daily basis.

In the short term, four and possibly five psychologists will be available to the department by the end of July 2010 bringing the total to 6 or 7. By the end of June, the University of Guam will be sending 6 master level behavior therapist psychology students to the Department for a final practicum before graduation in December 2010. The clinical psychologists will be providing supervision, but the students arriving are already trained to provide a certain level of

service. The Department is being reorganized to create a Psychology Division, under which will be the clinical psychologists, the behavioral psychologists, and personal care attendants.

The psychiatric technicians (psych-techs) will be engaged in the College of Direct Support program (See Section 3), in an effort to develop a new skill set, in terms of providing care and treatment to the consumers under their charge. The job descriptions of direct service workers will be standardized to include the training requirements and incentives will be offered for each training module completed.

A Training Division will be established and a model program adopted to provide routine recurrent training, as well as discipline specific specialized training with the assistance of a consultant as described in Section 15. A training day each quarter will be approved, where routine business will be suspended to encourage maximum attendance at the sessions. The frequency of training days will ensure that the Department's staff is adequately trained on the policies and procedures, as they are generated. Since a major challenge to implementing specialized mental health training programs is the amount of information that must be taught and digested, an approach will be employed, whereby several multimodal training modules will be offered. Each training topic will be broken down to contain objectives, outcomes, content assessment and demonstrated mastery of the material.

A visiting distinguished lecture series will be developed, in conjunction with local professional organizations and the University of Guam to bring outstanding presenters at the rate of 4 per year. One can safely assume that these presentations would also be well attended by mental health professionals on island (i.e. private practitioners, as well as those in the public realm). The underlying goal of such a program is, to not only to acquire knowledge with respect to specific skill sets, but establish and enhance working relationships, including the collegial exchange of ideas amongst the Department, sister Agencies and the private sector.

Evening psycho-educational classes will be established for both clients and family members, as the staff is shored up and thereby available to conduct the instruction.

In addition, the FMT will ensure that MDTT members are properly trained to write

professionally appropriate behavioral goals and objectives that include, when possible, input from the consumer and his/her family or guardian. Software will be purchased, where appropriate, to facilitate this process. The MDTT process will be streamlined, via policies and procedures, in order to provide the intensity of services, both assessment and treatment, where needed.

The FMT will also be expected see to it that the treatment process will provide each member of the target population a reasonable opportunity to function as independently and effectively as possible (as envisioned by the API). To that end, treatment planning should reflect an interdisciplinary process based upon reliable data and clearly measurable goals. The treatment plans themselves will be consistently scrutinized/assessed for their efficacy and where deemed appropriate, revised.

TIMELINE:

Continuous development with the assistance of consultants and in-house staff.

COST:

Actual cost of modification of the overall treatment process and training will be borne by other areas of the Plan of Action.

Section 12: Psycho-Pharmacology Practices

Challenge/Issue:

At present, there is no procedure in place to review the prescription practices of the psychiatrists. An oversight process should be implemented as a standard operating practice.

The computer software subscription to control inventory and ordering of medications used by the DMHSA has not been renewed for two years. As a result, the process for filling the medication needs of approximately 1500 consumers has been rather arcane. As opposed to purchasing medications from a wholesale distributor, the Department has been dealing with local pharmacies, which is both costly and inefficient. When DMHSA's formulary at the medication clinic exhausts its monthly supply, purchase orders are cut and disseminated to retail pharmacies on isle outpatient consumers are then sent to the retailers to have their prescriptions filled.

The hodge-podge of available medication at the Department's formulary, coupled with unreliable inventories at the local pharmacies, is troublesome to say the least. When the medication regimen of a consumer is interrupted or altered (i.e. alternate medications are substituted for the unavailable one that was originally prescribed) problem behavior and adverse side effects are a distinct reality.

Separate and apart from the safety concern, is the undeniable fact that the current practice results in overspending. Several incidents give pause for concern. For instance, over 350,000 expired pills were recently destroyed and errors with respect to ordering have been observed (i.e., although 100 vials were requested, 100 boxes were ordered, resulting in 2500 vials being received). The FMT has also borne witness to the fact that the current practice for tracking the inventory is flawed and there is no method to determine the formulary's monthly needs. To further compound the problem, the refrigerator in the pharmacy was not in service and since the air conditioning was also malfunctioning on occasion, some of the medications began to actually melt.

Finally, no psycho-educational classes are being conducted to inform clients, care givers or families about the importance of the respective medications, side effects, risks and benefits.

OVERSIGHT OF PSYCHOPHARMACOLOGICAL PRACTICES

The FMT could be expected to put together a Medical (Peer) Review Board, comprised of private physicians, to ensure that pharmacological and psychopharmacological practices comport with generally accepted professional standards. A review by this independent group would essentially examine whether the medications prescribed were professionally justified, carefully monitored, documented and reviewed by qualified staff. The FMT will ensure that staff are adequately trained and knowledgeable about the risks and side effects attendant to administering psychotropic medications. The Board is expected to meet monthly to review a select number of cases at each meeting.

In addition, DMHSA would be encouraged to explore purchasing new generation psychotropic medications for its formulary (access to the newer medications is important to the treatment of mental illness because they have fewer and less severe side effects than the older medications). The FMT shall facilitate communication between treatment team members, in an effort to promote a collaborative working relationship and thereby provide members of the target population with the most effective treatment and service, in keeping with generally accepted professional standards.

The FMT is in the process of developing a quarterly forecast and has made contact with Health and Human Services Supply Service Center to order medications at wholesale prices. Additionally, the FMT is facilitating the updating the software to monitor inventory, usage and dispensing, in an effort to improve accuracy, as well as save money. Down the road, as the billing system is brought on line, the FMT anticipates that medication costs will be charged to the appropriate institutions, Agencies and companies to supplant their respective cost which is presently absorbed by the Government of Guam.

The FMT recently requested a change in legislation to include the Department in the named Agencies authorized to order medications from manufacturers and wholesalers. The absence of DMHSA in the previous law was considered an oversight but prevented DMHSA from seeking the best price for medication, this perturbation was corrected with the passage of Bill 405 on June 30, 2010.

TIMELINE:

As soon as possible, but as early as July 2010. With the recent passage of legislation, and previous work on the inventory and ordering process by the FMT, the first order is expected to be made in July 2010.

Software renewal of subscription was made by the Department in May 2010. Training will be needed to fully implement the data system. EDC August 2010.

The Medical Review Board will be established via policy and procedure by March 2011 to provide peer review of medication practices.

COST:

No direct cost to the Plan for the annual subscription of the software module for medication inventory control since it has been factored into the Department's budget, as had the cost of the medications.

Overall, the Department should experience a savings estimated to be $300,000 annually with the use of the inventory control software and purchases from wholesalers rather that filling prescriptions at local drugstores charging full retail prices.

There may be a nominal cost associated with monthly Medical Review Board meetings, estimated to be $100 per member per meeting. FY 2011 - $2500.

Section 13: Advisory Council

Challenge/Issue:

The Department did have an Advisory Council but it was disbanded in 2002, because meetings had not been held for 12 months. The duties are clearly spelled out in local law, 10 Guam Code Annotated (GCA) and will assist the Department in sustaining the appreciable gains that can be expected over the course of the next few years.

COUNCIL ON MENTAL HEALTH AND SUBSTANCE ABUSE (ADVISORY COUNCIL)

As mandated by law, the Mental Health Advisory Council will be re-established.

10GCA, CH 86 Department of Mental Health and Substance Abuse

' 86107. Council on Mental Health and Substance Abuse.
(a) There is within the Department an Advisory Council for Mental Health, Alcohol and Drug programs and services known as the Advisory Council. The Council shall consist of seven (7) members appointed by the Governor and confirmed by the Legislature. The members of the Council shall serve for three (3) years; provided that of the members first appointed, two (2) shall serve for one (1) year, two (2) shall serve for two (2) years and three (3) shall serve for three (3) years.

(b) The Council shall annually elect a Chairperson, Vice-Chairperson and Recorder from among its membership. The Council shall meet at least once a month at such time and place as the Chairperson may designate. Meetings shall be well publicized and shall be open to the public. Executive sessions are permitted only in accordance with the Open Government Law. Four (4) members shall constitute a quorum of the Council for the transaction of business. The concurrence of four (4) members present shall constitute official action of the Council.

' 86108. Duties of Council.
The Council shall review and approve the plans and programs of the Department and for that purpose shall have the following duties:

1) Review and approve the Department's annual budget;
2) Review and approve the Department's Three Year Plan and its annual update;
3) Periodically review available services and facilities to determine mental health, drug and alcohol program needs;
4) Utilize the support and assistance of interested persons, including recovered clients, to encourage potential clients to undergo treatment voluntarily;
5) Review and comment on all new and renewed Federal grants

application.
6) Perform such acts as may be reasonably necessary to accomplish the purpose for which it was formed, subject, however, to the following conditions:

a) Adopt such rules and regulations pursuant to the administrative Adjudication Law as may be necessary for the exercise of the Departments powers, performance of its duties and administration of its operations.
(b) Set fees, pursuant to the Administrative Adjudication Law, for appropriate types of services, appropriate types of medication formulary, and appropriate types of supplies, except in so doing, such fees shall not be retroactive as to services, medications and supplies furnished prior to the effective date of the enactment of such fees.
(c) The schedule of fees shall be sufficient to recover the operating costs and fixed costs and to generate such revenue as is necessary to make the Department quasi-self-sustaining. The costs of any medical care and services rendered to any person under a medically indigent or assistance program as defined within Chapter 2 of this Title and/or Medicaid/medicare, shall be paid by the Department of Public Health and Social Services.
Annual Analysis Report to I Liheslaturan Guåhan [the Legislature].
As a means of assuring the People of Guam that the Department is cost effective in the delivery and performance of healthcare services mandated by law, the Council will establish monitors to measure the quality and appropriateness of services rendered, and the productivity and financial performance of the Department. The results of this measure shall be submitted to I Liheslaturan Guåhan [The Legislature] concurrently with any fee adjustments.
(d) The Council shall submit to I Liheslaturan Guåhan, for approval, a budget for the use of any funds collected through the implementation of a fee schedule.

Several community members have not only been approached, but expressed an interest in or are willing to participate in the revitalization of The Department by serving on the Advisory Council. Council meetings will be scheduled in accordance with the law to obtain their assistance in fine tuning the plan and providing information to the community at large. The following will be approached to sit on the Advisory Council: Joan Gill, M.D. (VA psychiatrist), Kirk Bellis, D.O. (private psychiatrist), Jaylene Kent, Ph.D. (President Elect of the Guam Psychological Association and private business owner), James Sattler, M.D. (Medical Director,

Guam Memorial Hospital), Steven S. Unpingco (Mental Health Court Presiding Judge) or his designee the Mental Health Court Coordinator, Marcelene Santos (Guam Public Guardian), Peter Roberto (Director Public Health and Social Services), Arlene Santos (Program Director, Catholic Social Services) and Bernie Grajek, (Director, Guma Mami Inc)

TIMELINE:

The Advisory Council will be established by March 2011.

COST:

Nominal cost would include payment for attendance at Board meetings as prescribed by local law. Seven members at $100 per monthly meeting – FY 2011 - $5000.

Section 14: Evidence Based Practices

Challenge/Issue:

At this juncture, it is unclear to the FMT that the Department is committed to using evidenced based practices (EBPs). For instance, the Department has neither established a training program to teach EBPs, nor does it have a quality assurance program to assess compliance with same.

EVIDENCE BASED PRACTICES (EBP)

All levels in the system of care will be structured around evidence based practices that are culturally sensitive to the Chamorro community. Education and training (see Training Section 15) of staff members will teach fidelity to evidence based practices, which have shown that services for people with severe mental illness have demonstrated positive outcomes in multiple research studies. Establish policies and procedures via Quality Assurance (QA) (see Section 16, QA) and assure models are being adhered to and used throughout the system.

In 1998 the Robert Wood Johnson Foundation convened a consensus panel of professionals and identified six practices with a strong evidence base:

Standardized Pharmacological Treatment
Illness Management and Recovery Skills
Supported Employment
Family Psychoeducation
Assertive Community Treatment
Integrated Dual Disorders Treatment (substance abuse and mental illness)

Since 1997 SAMHSA has refined the process of defining EBPs resulting in a web site: The National Registry of Evidenced Bases Practice and Practices (NREBPP) http://www.nrepp.samhsa.gov/index.asp which currently includes 164 evidenced based interventions. From the web site:

Evidence-Based Practice in the Context of NREPP

NREPP does not attempt to offer a single, authoritative definition of

evidence based practice. SAMHSA expects that people who use this system will come with their own perspectives and contexts for understanding the information that NREPP offers. By providing a range of objective information about the research that has been conducted on each particular intervention, SAMHSA hopes users will make their own judgments about which interventions are best suited to particular needs. Advancing evidence based practice remains at the core of SAMHSA's Science to Service Initiative. SAMHSA hopes that the new NREPP will play a major role in realizing this goal by disseminating timely information to the field about both the scientific basis and practicality of available interventions.

TIMELINE:

Continuous - beginning with implementation of the Department’s Training Program.

COST:

No direct cost to the FMT Plan of Action.

Section 15: Training

Challenge/Issue:

The Department has no training division. In fact, training has not been considered a priority for decades. The minimal training that does occur (i.e. CPR, CPI, fire and safety) is conducted in a haphazard fashion.

There is no orientation program for new employees or standards for customer service. The training that is provided is ill-attended and no follow-up or accommodations made for workers on either the swing or night shifts. Finally, the Department lacks a venue to conduct training.

TRAINING

A Training Division will be established with the assistance of a consultant. The division will be tasked with the development of a continuous training program for the entire staff at DMHSA, to determine reoccurring needs, schedule classes, secure instructors and monitor attendance. The FMT will support one training day per quarter. Routine operations will be suspended for this particular day and training will occur for all staff.

Furthermore, specialized or discipline specific training for nurses, psychologists, social workers, occupational therapists and others will be organized using local professionals. Those outside the Department will be invited to attend to encourage intra-collegial networking.

A distinguished visiting lecture series will be developed. The Plan will budget for the necessary funding to bring distinguished professionals to Guam, in order to hold one-day workshops for service providers in the Department and the community. Because of the widespread appeal that these lectures can expect to garner, the congregations will be conducted at local hotels. The local professional associations: psychology, psychiatry, counselors, social workers and the University will be asked to be members of a workgroup, to both orchestrate the series and identify distinguished lecturers. It is anticipated that this collaborative effort will foster an enduring bond between the service providers at the Department and those working in the community.

DMHSA does have a large room that is currently being used for storage, which could be

utilized to accommodate intra-department training sessions that consist of 50 to 75 people. Notwithstanding, larger (training) conference rooms are part of the architectural layout at the Center.

Both intra division and full staffing (case reviews) will become routine occurrences on a monthly basis. Often referred to as Abrown bag@ seminars, these activities generally take place over the lunch hour and foster communication by encouraging informal interdepartmental consultation.

TIMELINE:

Develop the specification, publish a RFP and secure a consultant on training, EDC Jan 2011
Establish a Training Division with the Department – EDC April 2011
Hire individuals to operate the Division EDC June 2011
Commence Training August 2011
Establish a workgroup to develop a distinguished presenter program – EDC December 2010
Conduct the first distinguished lecture series – March 2011 and every three months thereafter.
Convert storage room in class room with the construction of a storage facility on the grounds of DMHSA start Nov 2010 EDC June 2011

COST:

Training Consultant - FY 2011 - $200,000
Storage facility construction costs estimated to be $300,000
Training Director - $50,000
Training Coordinator (PC-II) - $35,000
Administrative Support - $25,000
Office Startup costs - $20,000

Section 16: Quality Assurance

Challenge/Issue:

There is no quality assurance or improvement Division at DMHSA. In addition, applications for grants is conducted in an ad-hoc manner. To further compound the issue, few policies and procedures exist which speak to assessing practices for adherence to evidence based practices. At present there are no concrete plans to attain accreditation.

QUALITY ASSURANCE

Responsibility for systematic monitoring and evaluation of the various aspects of the Department (which impact the API) to ensure that standards of care are being met, will invariably be borne by the FMT (while working in concert with the Quality Assurance Officer). Performance expectations, in terms of providing treatment and services to the target population will be keenly scrutinized.

One can safely visualize that the quality assurance process would include actively collecting data with respect to the quality of treatment and/or services rendered. This would entail assessing the data for possible trends/underlying causes, facilitating coordination between the different Divisions, initiating inquiry regarding perceived deficiencies, identifying corrective action and finally, monitoring whether appropriate remedies are achieved.

The establishment of the section will ensure the use of evidence based practices, fidelity to the policies and procedures, the identification of methods to improve programs and services, while simultaneously monitoring efficacy. Findings will be reported to the Director and Advisory Council. The section will be instrumental in any quest for accreditation (whether it be the Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF)), by determining the requirements and assuring compliance.

Included in the QA section will be a grant subsection to seek money which is available and assist divisions apply for grants to bring new programs to the Department, enhance current programs and comply with any reporting requirements.

TIMELINE:

Quality Assurance office will be established, and personnel hired starting in December 2010 and completed by March 2011.

COST:

Quality Assurance Director – 1 FTE - $50,000

Quality Assurance officer – 1 FTE - $45,000

Quality Improvement Officer – 1 FTE - $45,000

Special Projects Coordinator II – 1 FTE - $50,000

Special Projects Coordinator I – 1 FTE – $45,000

Administrative Support – 1 FTE - $25,000

Office start up costs – estimate $20,000

Section 17: Management Information System

Challenge/Issue:

DMHSA is not using an organized or centralized form to gather data, keep clinical notes, issue billing statements or track individual progress. An electronic system to compile the same data is similarly lacking. Although the Department did have access to Sequest's TIER system (purchased in about 2005), it has not kept up with annual subscriptions, rendering the system of little use. Furthermore, inadequate training was provided to those who happened to use the system and consequently, TIER was never properly customized to fit individual Divisions' requirements (it appears to have been of little value to either the Drug and Alcohol or Suicide Prevention Divisions).

MANAGEMENT INFORMATION SYSTEM (MIS)

President Obama has set the target date of 2014 to have all medical records in an electronic format. This task is being overseen by the Health Policy and Initiatives Office under the Lieutenant Governor. An RFP for a consultant has been drafted.

In 2005, the Department purchased the Sequest TIER Workflow System for Behavioral Health, however the system has not been fully implemented within the Department. Complaints are numerous and one often hears that the system is not user-friendly and cumbersome.

At this time, because the national health record system is in a state of change, it is difficult to determine what changes will be needed to meet the President's mandate, the clinicians' needs and the envisioned billing requirements attendant to a fee schedule. The computer system hardware may need to be upgraded and additional technicians hired to operate and maintain the system. The FMT will seek federal assistance to meet the President's mandate.

The goal is a responsive system; one that allows for accountability of the professionals' time, billing capabilities, a dictation system, electronic records keeping and meets accreditation requirements, as well as security mandates. To avoid duplication of effort, the Department will

wait for the report of the above-mentioned consultants before embarking on software and hardware improvements. Consultation is underway with SAMHSA to research Guam's needs and to obtain a viable data management system.

TIMELINE:

SAMHSA Consultant to create demonstration scenarios for three potential systems – EDC September 2010.

Selection and purchase of a computer based system – January 2011

Implementation of the desired system May 2011

Staff training to commence in July 2011

COSTS:

Hardware, storage units, to move the system from DMHSA to Department of Administration - $45,000 – FY 2011

Purchase of a data system - $200,000 – FY 2011

Information Management Assistant II - $40,000 – FY 2011

Information Management Assistant I - $30,000 – FY 2011

Section 18: Policies and Procedures

Challenge/Issue:

The Policies and Procedures (P&P) currently in use by the Department were approved for use circa 1988 - 1992 and have generally not be updated or revised.

POLICIES AND PROCEDURES

The FMT believe the P&Ps constitute the foundation for a sustainable mental health system on Guam. The P&Ps will provide guidance to future Directors and Division personnel on critical procedures, as well as day-to-day operations.

Although several P&Ps have been proposed by consultants, Department personnel and the Office of Community Integration, few have been approved and/or implemented. The FMT intends to utilize a consultant to assist with P&P development in certain areas. The Medical Consultants Network (MCN), with whom DMHSA has already contracted, will also be used and provides JCAHO-ready templates, along with a mechanism to track, disseminate and store approved P&Ps, via a web based system. (See http://www.mcn.com).

With the aid of the MCN system, the Department was able to identify and triage nearly 250 P&Ps, which the various divisions would like to implement. However any purported enthusiasm quickly dissipated and very few P&Ps were actually generated. Moreover, none appear to have been properly approved (i.e. subjected to the local Administrative Adjudication Act) or coordinated, much less implemented. Assuming *arguendo*, that proper development, coordination and approval was realized, training to staff with regard to implementation, is yet another adjunct that must be addressed.

The FMT, in concert with SAMHSA, will develop a full compendium of P&Ps. Implementation and training on these P&Ps will also be overseen by the FMT.

TIMELINE:

RFP written to secure a clinical consultant to assist with the P&P process by November 2010.

Producing and revising P&Ps is a continuous process. The initial set of P&Ps (estimate 50) will be produced and where appropriate submitted to the AAA process by December 2010.

COST:

Clinical Consultant - $500,000 - FY 2011

Section 19: Waitlist

Challenge/Issue:

Since December of 2005, the Department has been operating under an Interim Wait List Policy and Procedure. A Waitlist P&P was offered to the Plaintiff's attorney in September 2009, but was rejected because it was not client-centered. Notwithstanding, a finalized version has yet to be rewritten.

FINALIZED WAIT LIST

The FMT will undertake responsibility for ensuring that the long-awaited finalized version of the Wait List (along with the concomitant grievance process) is not only developed, but implemented.

TIMELINE:

The Waitlist P&P will be completed by September 2010 and submitted for review to Counsel for both parties. Compromises will be made, as necessary, by the end of October 2010. The Waitlist will be submitted to the AAA 90-day process in November 2010, to be finalized in March 2011.

COST:

None

Section 20: Miscellaneous Programs or Expenditures

1. **The DMHSA facility has no security.** Numerous items have been stolen but more importantly, the staff and clients are exposed to unchecked threats from clients and their respective family members on occasion. A grant from the Department of Homeland Security has been applied for, which would underwrite the attendant costs for a video monitoring system, metal detector and an emergency alert system. However no funds were available from this grant source to cover the concomitant cost for securing a minimal security force.

TIMELINE:

Hire a security team of 4 officers and 1 supervisor by October 2010

COST:

Security Supervisor – 1 FTE - Salary $33,000 – FY 2011

Security Officers – 4 FTE – Salary $28,000 – FY 2011

2. **The main DMHSA facility is in a need of repairs and paint**. The Maintenance Division has requested additional maintenance personnel to maintain the current facilities and attend to the ones that are to be constructed.

TIMELINE:

Repairs will commence in December 2010 and continue for several months until complete. Maintenance personnel will be hired in FY 2011.

COST:

Maintenance Supervisor – 1 FTE – salary $45,000 – FY 2011

Maintenance Specialist – 1 FTE – salary $45,000 – FY 2011

Maintenance Workers - 2 FTE – salary $35,000 – FY 2011

Replace third floor air-conditioner - $350,000 - FY 2011

Repair generator - $25,000 – FY 2011

Paint main facility inside and outside - $100,000 – FY 2011

Repair inpatient ward furniture - $30,000 – FY 2011

3. **Office space: With the number of new hirers being recruited, 5000 square feet of** additional office space is needed until the Center is opened in two years.

TIMELINE:

Obtain office space near the main facility by January 2011.

COST:

Estimated $2.00/sq. ft or $10,000 per month - $90,000 – FY 2011 and $120,000 in FY 2012.

4. **The social work division requested an auxiliary fund for minor miscellaneous** expenditures such as taxi fair, emergency clothing, etc.

TIMELINE:

Funds would be made available upon plan approval.

COST:

Estimated at $500 per month – $6,000 - FY 2011

5. **Neither The Division of Professional Services (Psychiatry) nor the Psychology** Division have administrative support staff assigned to them and as a result must type their own reports and clinical notes resulting in the poor utilization of these professionals' time. No system of dictation exists within the Department.

TIMELINE:

Hirer administrative support staff for both divisions by November 2010.

COST:

Administrative Support II – FTE 2 – salary $25,000 – FY 2011 - $50,000

Administrative Support III – FTE 1 – salary $30,000 – FY 2011 - $30,000

Dictation network software – FY 2011 - $1000

6. **The Nursing Division currently uses overtime and 12-hour shifts to provide proper** coverage of psychiatric technicians and nurses to the inpatient units. Additional nurses and psychiatric technicians were requested to decrease the "burnout" rate, adequately cover the units in a more economic fashion, handle off-hour intake processing and staff the mobile outreach team.

TIMELINE:

Complete hiring the desired personnel by December 2010.

COST:

Registered Nurses - 5.5 FTE – salary $55,000 – FY 2011 - $302,500

Licensed Practical Nurses – 3 FTE – salary $50,000 – FY 2011 - $150,000.

Psychiatric Technicians – 7 FTE – salary $45,000 – FY 2011 - $315,000.

7. **The Human Resources Division has only one individual assigned, however there is** an anticipated need for additional staff to process the increased workload associated with the Plan of Action.

TIMELINE:

October 2010 to hire one additional staff member in HR

COST:

Personnel Assistant II – 1 FTE - salary $30,000 – FY2011 - $30,000

8. **The Department has an older fleet of vehicles used in the transportation of clients to** and from appointments, residential placements, service the mobile outreach team, etc. Accordingly, an additional 8 vehicles are requested to perform these various duties.

TIMELINE:

Vehicles will be phased in over the next three years.

COST:

2 Vehicles (1 passenger car and 1 van) FY2011 - $60,000

3 Vehicles (3 passenger cars) – FY 2012 - $80,000

3 Vehicles (2 passenger cars and 1 van) FY 2013 - $100,000

Section 21: Budget

Challenge/Issue:

The aggregate budget for the transformation of mental health services will calculated in two parts: 1) the cost associated with transformation and 2) an estimated Departmental operating budget at the end of the three-year transformation to sustain the changes.

BUDGET

Capital improvements:

There appear to be approximately 310 individuals that come within the purview of the target population. It currently costs Guam roughly $80,000 per year for each client in the RGHs, under the contracts the Department has entered into with service providers/vendors. The number of clients coveting community and group home placement under the present system is likely to increase to nearly 140 from the current 50-80, as the families caring for the many individuals advance in age (i.e. a price tag of approximately 11.2 million). This figure of 140, includes the 30 individuals on the wait list seeking immediate placement. With the increased utilization of Shelter Plus Care, along with other HUD funded community integration programs, the provision of services at the Center, the use of community based services, such as the Assertive Community Team [see Section 5] and the reorganization of homes and apartments, Guam will experience a decrease in the attendant cost of caring for the target population to well below the estimated projected cost of 11 million dollars.

The cost of services to those in Shelter Plus Care is estimated at $25,000 annually (local match) for each of the fifty (50) clients and when added to the 90 clients in group homes after The Center is fully functioning, this will yield a total of 3.5 million dollars for services for the 140 clients in this class. This does not include the cost of services provided by The Center (160 remaining clients in the target population), however the personnel currently on staff, along with projected new hires, will be providing services to both groups.

In sum, each client moved into the community setting saves the Government of Guam

approximately $55,000 annually in the current system. Furthermore, for the clients in residential placements under this plan, cost per client is reduced from $80,000 to $52,000 (includes housing at $27,000 and services $25,000).

Major costs related to the Plan outlined herein, are:

Construction and furnishing of The Center	$8, 360,000
Construction or rental and furnishing the residential array of housing	$3,170,000
Salaries of new personnel*	6,000,000
Training	$178,000
Quality Assurance	$280,000
Consultants	$1,000,000
Receiver expenses and staff salaries	$2,300,000
Repairs, equipment, rental, etc.	1,600,000
Total Cost Estimate of this Plan:	23,915,884**

*New hires= salaries will be rolled into the Departments annual budget as soon as practical.
** See Exhibit 4, Expense spreadsheet for calculations

Annual Department Budget:

The two departments (DISID and DMHSA) have a combined budget (2011) which totals $26,786,520. Despite the increase in personnel costs that can be anticipated under the Plan, one must take into consideration the savings associated with 1) an economy of scale, given the fact that operations will be streamlined into a single department; 2) the return of those receiving treatment off-island and 3) the restructuring of residential housing utilizing Federal funds, coupled with the envisioned income generated from an implemented fee schedule. Bottom line: the Government of Guam should see a substantial overall reduction in the Department's annual budget, which pursuant to the Plan, should hover around 20 to 22 million (i.e. from the general fund), therefore netting the island a savings of up to 6 million dollars per year using 2010 figures.

Section 22: Duration/ Timeline Summary

Challenge/Issue:

It should come as no surprise that both DMHSA and DISID have been in disarray for quite some time, resulting in poor service delivery and routine criticism by other agencies, as well as the local Judiciary. Immediate, decisive action will be needed for the transformation to, not only improve services, but cultivate respect.

ANTICIPATED DURATION OF THE RECEIVER'S TENURE

Under the Plan, a significant reorganization of the Department will take place and as part and parcel of this transformation, the tenor of the Departmental-wide attitude altered. In short, it is safe to say that staff are currently dispirited and as a result, arguably not "putting their best foot forward." There is infighting at the highest levels, assignment of blame and dissimulation. Furthermore, the line staff feel as though they are essentially disenfranchised, given the lack of support from management. Since input from being these employees is largely discounted, those "in the trenches" feel seemingly unimportant, resulting in the absence of any modicum of esprit de corps.

In addition to the metamorphosis that will invariably occur, in terms of the rank and file's disposition, a similar transformation can be expected when the Department's glaring need for a remarkable amount of training is addressed. Building a logical, well planned training program takes time; however this process will start immediately and continue on well past the Federal Management Team's tenure. Simultaneously, major construction projects *to wit*: the Center and alternative facilities will be undertaken. The Center will likely take two years to complete, but less time is anticipated for construction of the housing facilities. Community placements and accompanying integrated services will be started and well established within six months. Management of records and documentation of services can be expected to commence almost immediately, with training on the system and full utilization expected in six months. This will be followed by a billing system. Finally, P&Ps and legislation projects will also begin immediately.

The best estimate for the duration of the FMT is 30 to 36 months. After that time, the Department will be in full compliance with the API and management of operations transitioned

back to the Government of Guam, with any unused funds set aside for the subject Plan's implementation.

Section 23: Conclusion

CONCLUSION

Over six (6) years have now elapsed since the Judgment was entered and API issued (i.e. June 8, 2004). The Defendants' inability to care for the vulnerable target population has been the subject of repeated Judgments (i.e. Findings of Contempt) and Orders (attempting to focus attention on various action-items, for which compliance with the mandates of the API was still wanting). Given the futility of the Defendants' heretofore efforts, a vision is critical, in order to overhaul the current dysfunctional mental health system, coordinate the disjointed attempts and galvanize the workers. Toward that end, the proposed Plan endeavors to provide the Plaintiffs and "those individuals similarly situated" with adequate housing, treatment and care in a community-based setting. The Plan not only addresses the requirements set forth in the API, but constitutes a blueprint for a fundamental shift to a more accessible, responsive and integrated community-based mental health system.

The goals embodied within this subject Plan emphasize development of an enduring infrastructure, the provision of care, treatment and services on an individualized basis, true communal integration, accountability and strengthening partnerships with sister Agencies. Common sense would seem to dictate that both the cost and proposed time frame associated with implementation of the Plan, if viewed in juxtaposition to the current aggregate budget for the two Institutional Defendants, coupled with their unsuccessful efforts to date, will undoubtedly maximize utility.

In sum, implementation of the Plan will enable the Defendants to finally come into compliance with what was envisioned by the API and simultaneously transform the mental health care system on Guam, which can only redound to the benefit of those who currently linger "in the shadows of life."

EXHIBIT 1

The Proposed Treatment Center

Federal Management Team

Plan of Action
Estimated Costs

12/1/2010

	2010									2011										
Activity	**April**	**May**	**June**	**July**	**August**	**September**	**October Begin FY2011**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October Begin FY2012**	**November**
The Treatment Center																				
TC Director 1 FTE 85k																				
TC administrative support 2 FTE 25k																				
TC IT coordinator 1 FTE					2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083
Occupational Therapists II 2 FTE 50K						8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333
Occupational Therapists I 3 FTE 40K						10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
Behavioral Therapists 5 FTE 40 K				interns	interns	interns	interns	interns	interns	16,667	16,667	16,667	16,667	16,667	16,667	16,667	16,667	16,667	16,667	16,667
Behavior Therapist II $45K						3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750
Recreation Therapist 32K						2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667	2,667
Physical Therapists 2 FTE 50K															8,333	8,333	8,333	8,333	8,333	8,333
Hearing impaired instructor .3 FTE @70K																				
Sight impaired instructors 1 FTE @70K																				
Activities Coordinator 1 FTE 50K				4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167
Medical Service MD - .3 FTE 200K																				
Program Coordinators 3 FTE @30k																				
The Center									8,360,000											
PCA Program																				
PCA - Program director est. salary and benefits 69K				5,750	5,750	5,750	5,750	5,750	5,750	5,750	5,750	5,750	5,750	5,750	5,750	5,750	5,750	5,750	5,750	5,750
PCA attendants salary and benefits est. 25K						2,083	2,083	2,083	2,083 #	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083
PCA add - 2 = total of 3						4,166	4,166	4,166	4,166 #	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166
PCA add - 2 = total of 5							4,166	4,166	4,166 #	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166
PCA add - 2 = total of 7									4,166 #	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166
PCA add - 2 = total of 9										4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166
PCA add - 2 = total of 11										4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166
PCA add - 2 = total of 13											4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166
PCA add - 2 = total of 15												4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166
PCA add - 2 = total of 17													4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166
PCA add - 2 = total of 19														4,166	4,166	4,166	4,166	4,166	4,166	4,166
PCA add - 2 = total of 21															4,166	4,166	4,166	4,166	4,166	4,166
PCA add - 2 = total of 23																4,166	4,166	4,166	4,166	4,166
PCA add - 2 = total of 25																	4,166	4,166	4,166	4,166
PCA add - 2 = total of 27																		4,166	4,166	4,166
PCA add - 2 = total of 29																			4,166	4,166
PCA add - 2 = total of 31																				
Training Materials						50,000										50,000				
Pharmacy																				
Pharmacy Software		0																		
Pharmacy account with HHS			0																	
Pharmacy Personnel				2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Counseling Division																				
Counselors - licensed IMFT (PSW - !!) $45K - 6 FTE							22,500	22,500	22,500 #	22,500	22,500	22,500	22,500	22,500	22,500	22,500	22,500	22,500	22,500	22,500
Assertive Community Team																				
Psychiatrist - 1 Salary 240K includes benefits							20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000

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Estimated Costs

Nurse salary 55K includes benefits							4,583	4,583	4,583		4,583	4,583	4,583	4,583	4,583	4,583	4,583	4,583	4,583	4,583
Community Support Services																				
SW Administrator 1 55k							4,583	4,583	4,583	#	4,583	4,583	4,583	4,583	4,583	4,583	4,583	4,583	4,583	4,583
SW-III---- 2@40k							3,333	3,333	3,333	#	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333
SW - II - 3 @35K							5,833	5,833	5,833	#	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833
SW-I------3 @30							5,000	5,000	5,000	#	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Admin Assistant 25k							2,083	2,083	2,083	#	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083
Nursing																				
RN --5 (1 under ACT) 55k						22,917	22,917	22,917	22,917		22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917	22,917
Psych Tech 7 45k						26,250	26,250	26,250	26,250		26,250	26,250	26,250	26,250	26,250	26,250	26,250	26,250	26,250	26,250
Intake section																				
SW - II - 1 FTE @ 35K							2,917	2,917	2,917	#	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917
SW - III - 1 FTE @ 40K							3,333	3,333	3,333	#	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333
LPN 3 50k						10,000	10,000	10,000	10,000		10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
Consultant																				
Clinical Management									500,000											
Training									200,000											
Vocational									300,000											
Construction									700,000											
Residential Homes																				
4 BR houses 4											1,500,000									
Cluster Apartments 2											1,470,000									
Rentals											15000	15000	15000	15000	15000	15000	15000	15000	15000	15000
Quality Assurance																				
Quality Assurance Director (Same as HH director) 50k							4,167	4,167	4,167		4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167
Quality Assurance Officer 45k							3,750	3,750	3,750		3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750
Quality Improvement Officer 45k							3,750	3,750	3,750		3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750
Administrative Assistant 25k																				
Special Projects Coordinator (Grants) 50k							4,167	4,167	4,167		4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167
Assistant Special Projects Coordinator 45k							3,750	3,750	3,750		3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750
Special Projects Admin support 25k							2,085	2,086	2,087		2,089	2,090	2,091	2,092	2,093	2,094	2,095	2,096	2,097	2,098	2,099
Start up cost							20,000													
Training																				
Training Director (Same as HH) 50k							4,167	4,167	4,167		4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167
Training Coordinator (PCII) 35k							2,917	2,917	2,917		2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917
Admin Assistant 25k							2,085	2,086	2,087		2,089	2,090	2,091	2,092	2,093	2,094	2,095	2,096	2,097	2,098	2,099
Office start up cost								20,000												
Establish Professional Library								1,000	1,000		1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Distinguished Lecture Series							12,000				12,000			12,000			12,000			12,000
Information Management																				

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Estimated Costs

Information Management assistant 40k					3,333	3,333	3,333	3,333	3,333	#	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333
Information Management Assistant 30k					2,500	2,500	2,500	2,500	2,500	#	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Hardware DHs							45,000															
Data system software									200,000													
Facility Maintenance																						
Maint Leader -- 1 45k							3,750	3,750	3,750		3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750
Maint Specialist 1 45k							3,750	3,750	3,750		3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750
Maint Workers - 2 35k							5,833	5,833	5,833		5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833
Clerk - II --1 23k							2,083	2,084	2,085		2,087	2,088	2,089	2,090	2,091	2,092	2,093	2,094	2,095	2,096	2,097	
Human Resources Assistant				1,833	1,833	1,833	1,833	1,833	1,833		1,833	1,833	1,833	1,833	1,833	1,833	1,833	1,833	1,833	1,833	1,833	1,833
Safety Officer				2,333	2,333	2,333	2,333	2,333	2,333		2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333
Other Expenses																						
Main facility repair																						
Replacing Aging Air Conditioners									350,000													
Paint Facility									100,000													
Repair Generator									25,000													
ward furniture				30,000																		
SW Aux fund				500	500	500	500	500	500		500	500	500	500	500	500	500	500	500	500	500	500
fund office space until center completed				10,000	10,000	10,000	10,000	10,000	10,000		10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
Storage Building - 3000 sf				300,000																		
Vehicles																						
1 van and 1 car											60,000											
3 cars																						
2 cars and 1 van																						
FMT																						
Team per Month				73,250	73,250	73,250	73,250	73,250	73,250	#	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250
Security																						
Equipment from Homeland Security				0	0	0	0	0	0													
Security Supervisor 1				2,750	2,750	2,750	2,750	2,750	2,750		2,750	2,750	2,750	2,750	2,750	2,750	2,750	2,750	2,750	2,750	2,750	2,750
Security Officers 4				9,333	9,333	9,333	9,333	9,333	9,333		9,333	9,333	9,333	9,333	9,333	9,333	9,333	9,333	9,333	9,333	9,333	9,333
Dietician 30K				2,500	2,500	2,500	2,500	2,500	2,500		2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Admin support for Psychiatry Psychology																						
Admin support II -2FTE@ 35k				5,833	5,833	5,833	5,833	5,833	5,833	#	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833	5,833
Dictation software				1,000																		
Administrative Secretary 1 @35K				2,917	2,917	2,917	2,917	2,917	2,917	#	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917
Total per month				454,167	131,083	271,249	422,836	366,839	11,086,008	#	3,433,013	395,182	399,351	415,520	407,689	420,191	486,360	428,529	432,698	448,867	436,870	

Federal Management Team

Plan of Action
Estimated Costs

12/1/2010

2012													2013											
December	January	February	March	April	May	June	July	August	September	October Begin FY 2012	November	December	January	February	March	April	May	Jun	Jul	Aug	Sep	October Begin FY 2013		Row Total Personnel
																								0
			7,083	7,083	7,083	7,083	7,083	7,083	7,083	7,083	7,083	7,083												70,833
			4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167												41,667
2,083																								35,417
8,333																								133,333
10,000																								160,000
16,667																								200,000
3,750																								60,000
2,667																								42,667
8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333												158,333
													1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750			15,750
													1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750			15,750
4,167																								70,833
													5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000			45,000
													7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500			67,500
																								0
																								0
																								0
5,750																								97,750
2,083																								35,417
4,166																								70,822
4,166																								66,656
4,166																								58,324
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												104,150
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												104,150
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												99,984
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												95,818
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												91,652
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												87,486
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												83,320
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												79,154
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												74,988
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												70,822
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												66,656
4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166	4,166												58,324
							50,000																	
																								0
																								0
																								0
																								0
																								0
																								0
																								0
																								0
																								0
2,000																								34,000
																								0
																								0
22,500																								360,000
																								0
																								0
																								0
20,000																								300,000

4,583																							68,750
																							0
																							0
																							0
4,583																							73,333
3,333													3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333	3,333		83,333
5,833													2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917		119,583
5,000													2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500		102,500
2,083																							33,333
																							0
																							0
22,917																							366,667
26,250																							420,000
2,917																							
3,333																							
10,000																							160,000
																							0
																							0
																							0
																							0
																							0
																							0
15000																							
																							0
																							0
																							0
																							0
4,167																							62,500
3,750																							56,250
3,750																							56,250
																							0
4,167																							62,500
3,750																							56,250
2,100																							31,397
																							20,000
																							0
																							0
																							0
																							0
																							0
4,167																							62,500
2,917																							43,750
2,100																							31,397
																							20,000
1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000								31,000
	12,000			12,000			12,000			12,000			Department to bring the expense of this program into their annual budget										108,000
																							0
																							0

Federal Management Team

Plan of Action
Estimated Costs

12/1/2010

3,333																							60,000
2,500																							45,000
																							0
																							0
																							0
																							0
																							0
3,750																							56,250
3,750																							56,250
5,833																							87,500
2,098																							31,367
																							0
																							0
1,833																							31,167
2,333																							39,667
																							0
																							0
																							0
																							0
																							0
																							0
																							0
500																							
10,000	10,000	10,000	10,000	10,000	10,000	10,000																	
																							0
																							0
																							0
																							0
																							0
	80,000																						
													100,000										
																							0
																							0
																							0
73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250	73,250						
																							0
																							0
																							0
																							0
2,750																							46,750
9,333																							158,667
																							0
2,500																							42,500
																							0
5,833																							105,000
																							0
2,917																							52,500
																							0
																							0
																							0
441,039	234,575	142,575	153,825	165,825	153,825	153,825	205,825	143,825	143,825	155,825	143,825	143,825	199,000	99,000	99,000	98,000	98,000	24,750	24,750	24,750	24,750	24,011,384	
																							6,038,467

Item	Annual Cost 1 RGH - 8 cl	per client	
staff =6 FTE 22K	132000		
utilities @ 1000/m	12000		
mx @ 500/m	6000		
transportation @ 20000/y	20000		
supplies and food 15/d	43800		
	213800		26725
services			25000
			51725

Supervisors	Professional	Other	Number
Center Director 1 FTE 85k			1
		Center administrative support 2 FTE 25k	2
		Center IT coordinator 1 FTE	1
	Occupational Therapists II 2 FTE 50K		2
	Occupational Therapists I 3 FTE 40K		3
	Behavioral Therapists 5 FTE 40 K		5
	Behavior Therapist II $45K		1
	Recreation Therapist 32K		1
	Physical Therapists 2 FTE 50K		2
	Hearing impaired instructor .3 FTE @70K		0.3
	Sight impaired instructors 1 FTE @70K		1
	Activities Coordinator 1 FTE 50K		1
	Medical Service MD - .3 FTE 200K		0.3
		Program Coordinators 3 FTE @30k	3
PCA - Program director est. salary and benefits 69K			1
		PCA attendants salary and benefits est. 25K	1
		PCA add - 2 = total of 3	2
		PCA add - 2 = total of 5	2
		PCA add - 2 = total of 7	2
		PCA add - 2 = total of 9	2
		PCA add - 2 = total of 11	2
		PCA add - 2 = total of 13	2
		PCA add - 2 = total of 15	2
		PCA add - 2 = total of 17	2
		PCA add - 2 = total of 19	2
		PCA add - 2 = total of 21	2
		PCA add - 2 = total of 23	2
		PCA add - 2 = total of 25	2
		PCA add - 2 = total of 27	2
		PCA add - 2 = total of 29	2
		PCA add - 2 = total of 31	2
		Pharmacy Personnel 2 PTE	0.7
	Counselors - licensed IMFT (PSW - !!) $45K - 6 FTE		6
	Psychiatrist - 1 Salary 240K includes benefits		1
	Nurse salary 55K includes benefits		1
SW Administrator 1 55k			1
	SW-III---- 2@40k		2
	SW - II - 3 @35K		3

	SW-I------3 @30		3
		Admin Assistant 25k	1
	RN --5 (1 under ACT) 55k		5
	SW-II Intake		1
	SW-II Intake		1
	LPN 3 50k Intake		3
		Psych Tech 7 45k	7
Quality Assurance Director (Same as HH director) 50k			1
		Quality Assurance Officer 45k	1
		Quality Improvement Officer 45k	1
		Administrative Assistant 25k	1
		Special Projects Coordinator (Grants) 50k	1
		Assistant Special Projects Coordinator 45k	1
		Special Projects Admin support 25k	1
Training Director (Same as HH) 50k			1
		Training Coordinator (PCII) 35k	1
		Admin Assistant 25k	1
		Information Management assistant 40k	1
		Information Management Assistant 30k	1
		Maint Leader -- 1 45k	1
		Maint Specialist 1 45k	1
		Maint Workers - 2 35k	2
		Clerk - II --1 23k	1
		Human Resources Assistant	1
		Safety Officer	1
		Security Supervisor 1	1
		Security Officers 4	4
		Admin support II -2FTE@ 35k	2
		Administrative Secretary 1 @35K	1
TOTAL			118.3

FMT

Suggested Fund Infusion from Government of Guam
in Support of the
Plan of Action

12/1/2010

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1								**$2,010**								
2	**Activity**		**April**	**May**	**June**	**July**	**August**	**September**	**October Begin FY2011**	**November**	**December**		**January**	**February**	**March**	**April**
3																
4																
5	Total per month					$454,167	$131,083	$271,249	$422,836	$366,839	$11,086,008		$3,433,013	$395,182	$399,351	$415,520
6											$8,750,000					
7							$856,499				$2,336,008					
8											(consultants 1.7)		(Resid 2.97)			
9																
10																
11																
12																
13																
14																
15	From GOG								$2,000,000		$3,000,000		$3,000,000		$1,000,000	$1,000,000
16																
17																
18						BALANCE			$1,577,164	$1,210,325	$1,241,156		$808,143	$412,962	$1,013,611	$1,598,091
19						excluding current res balance)										
20																
21																
22									Center is separate financing				$8,400,000	DOR		
23																
24									AC replace/repair				$350,000	EPA		
25													=========			
26													$8,750,000			
27																
28									Other construction 4 homes, storage, 2 cluster, separate functioning				$3,000,000	DOR or usda but are listed in Jan 11		
29																
30																
31																
32																
33																
34																
35																
36																

FMT

Suggested Fund Infusion from Government of Guam
in Support of the
Plan of Action

12/1/2010

	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF
1		**$2,011**													**$2,012**	
2	**May**	**June**	**July**	**August**	**September**	**October Begin FY2012**	**November**	**December**		**January**	**February**	**March**	**April**	**May**	**June**	**July**
3																
4																
5	$407,689	$420,191	$486,360	$428,529	$432,698	$448,867	$436,870	$441,039		$234,575	$142,575	$153,825	$165,825	$153,825	$153,825	$205,825
6																
7																
8			$2,000,000													
9																
10																
11																
12																
13																
14																
15		$1,000,000				$2,000,000								$1,000,000		
16																
17																
18	$1,190,403	$1,770,212	$1,283,852	$855,323	$422,625	$1,973,758	$1,536,888	$1,095,849		$861,273	$718,698	$564,873	$399,047	$1,245,222	$1,091,397	$885,571
19																
20																
21																
22																
23																
24																
25																
26																
27																
28																
29																
30																
31																
32																
33																
34																
35																
36																

FMT

Suggested Fund Infusion from Government of Guam
in Support of the
Plan of Action

12/1/2010

	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW
1											**$2,013**						
2	**August**	**September**	**October Begin FY 2012**	**November**	**December**		**January**	**February**	**March**	**April**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**October Begin FY 2013**	
3																	
4																	
5	$143,825	$143,825	$155,825	$143,825	$143,825		$199,000	$99,000	$99,000	$98,000	$98,000	$24,750	$24,750	$24,750	$24,750		$24,011,384
6																	
7																	
8																	
9																	
10																	
11																	
12																	
13																	
14																	
15			$1,000,000													$15,000,000	
16																	
17																	
18	$741,746	$597,921	$1,442,095	$1,298,270	$1,154,445		$955,445	$856,445	$757,445	$659,445	$561,445	$536,695	$511,945	$487,195	$462,445		
19																	
20																$8,750,000	
21																$350,000	
22																	
23																	
24																$24,100,000	
25																	
26																	
27																	
28																	
29																	
30																	
31																	
32																	
33																	
34																	
35																	
36																	

Included in this figure is $2,970,000 for construction of the residential homes which may be financed

Excess to be returned to the General Fund